DOCTOR'S LIEN
AND RELEASE OF MEDICAL DOCUMENTS

SOUTHERN CALIFORNIA
INJURY TREATMENT CENTER
15857 POMONA RINCON ROAD
CHINO HILLS, CA 91709
PH: 844-787-3286
FX: 909-591-0538

Attorney Name:_____
Address: _____
_____
_____

TO ATTORNEY ON THE CASE OF: _____
DATE OF INJURY: _____

This is a contract and a legal binding document which binds the attorney and patient to ensure that the doctor is paid for his services once the case is settled or a verdict is received. PLEASE SIGN AND FAX BACK TO (909) 591-0538.

I do hereby authorize **Southern California Injury Treatment Center**, to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, etc., in regards to the accident dated _____**.**

I hereby authorize and direct you, as my attorney for the personal injury case, to pay directly to **Southern California Injury Treatment Center** such sums as may be due and owing him/her for medical services rendered me both by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, or verdict as may be necessary to adequately protect such lien.

This is a third party lien given by the undersigned client to the benefit of the services for the above mentioned case. Your client instructs you not to revise this agreement and sign it immediately. If you fail to sign this document within the specified time, you will be in direct conflict with client instructions.

_____
PATIENT INITIALS

I understand that I am directly responsible for the said medicals and for all medical bills incurred for services regardless of the outcome of the case. **I understand, that if the doctor is not successful after due diligence in contacting the attorney or if the attorney refuses to cooperate, that this lien will be void and I am personally responsible for the outstanding medical bills**.

_____ _____
PATIENT SIGNATURE DATE

_____
PRINT NAME

The undersigned being the attorney for the injured above mentioned party hereby agrees to observe all the terms of this agreement between the doctor and the client and agrees to withhold such sums for any settlement, judgment or verdict as may be necessary to protect said doctor's lien. If dispute arises from this agreement and if the doctor prevails, the attorney or patient, as ordered by court, will be responsible to pay for **actual attorney fees and costs**.

A COPY OR A FAXED COPY OF THIS DOCUMENT IS A VALID AS THE ORIGINAL

_____ _____
ATTORNEY SIGNATURE DATE

Thank you for choosing Southern California Injury Treatment Center. Please take the next few minutes to complete the following paperwork. Answer each question with as much detail as possible. If you need more room, please use the back of this paper.

PATIENT DEMOGRAPHICS

Name: _____ Date: _____

Social security Number: ___ - ___ - ___ Driver's License Number: _____

Date of birth: _____ E-Mail address: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Business Phone: _____

Sex (Circle one): Male Female

Marital Status (Circle): Single Married Domestic Partner Divorced Separated Widowed

Spouse's Name: _____ # of Children: _____ Ages: _____

Emergency Contact Name: _____ Relationship: _____

Contact Phone: _____

How did you hear about us? (Please circle) Attorney Doctor Office Other: _____

Referred by: _____ City: _____
(NAME)

PLEASE PROVIDE ALL PERTINENT INFORMATION REGARDING YOUR CAR AND/OR INSURANCE COVERAGE. IF YOU HAVE SECONDARY INSURANCE PLEASE GIVE INFO FOR BOTH PARTIES.

INSURANCE INFORMATION

AUTO INSURANCE NAME: _____
POLICY NUMBER: _____
ADDRESS: _____
ADJUSTER NAME: _____ PH: _____
CLAIM NUMBER: _____
POLICY LIMIT: _____

OTHER PARTY INSURANCE INFORMATION

AUTO INSURANCE NAME: _____
POLICY NUMBER: _____
ADDRESS: _____
ADJUSTER NAME: _____ PH: _____
CLAIM NUMBER: _____
POLICY LIMIT: _____

SOUTHERN CALIFORNIA INJURY TREATMENT CENTER
15857 POMONA RINCON ROAD ● CHINO HILLS, CA
91709 PH: 844-787-3286 ● FAX: 909-591-0538

AUTHORIZATION OF BENEFITS

I, _____ assign any and all rights and benefits under my policy to the following doctor or facility:

Southern California Injury Treatment Center
15857 Pomona Rincon Road, Chino Hills, CA 91709

I ask that any and all checks due to me under my policy to be made out to the doctor or facility mentioned above. If my policy has a prohibition of assignment clause and does not allow assignment of benefits under my policy, then I instruct my insurance company to make the check payable to me but mail the check to the address mentioned above. Any failure to comply with this assignment will be violation of Insurance Code Section 790.03 and Insurance Regulation and will be considered a violation of my rights under the policy.

Authorization to Release Information

I hereby authorize **Southern California Injury Treatment Center** to: (1) release any information necessary to insurance carriers regarding my illness and treatments, (2) process insurance claims generated in the course of examination or treatment, and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **Southern California Injury Treatment Center** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid and original.

The payment under the policy should be mailed to my provider at once and no unnecessary delays are acceptable.

Date: _____

Print Name: _____

Signature: _____

MEDICAL INFORMATION RELEASE

I hereby authorize (name and address of healthcare provider)

_____

_____

to release/disclose my personal health information (PHI) for purposes of payment, health care operations and treatment. The information and records, which may be released to any medical psychiatric, psychological, psychotherapy, alcohol and/or drug abuse records and/or information, which he/she may have regarding.

_____, _____

(Patient Name) (Date of birth)

Examples of these types of uses and disclosures include:

PAYMENT: We use and disclose your PHI in order to process claims and seek reimbursement for your health expenses covered by an insurer.

TREATMENT: We may disclose your PHI to assist in your health care (doctors, pharmacy and others) in your diagnosis and treatment.

OTHER PERMITTED OR REQUIRED DISCLOSURES OF YOUR PHI:

AS REQUIRED BY LAW: We may disclose your PHI when required to do so by law (i.e., Workers' Compensation).

PUBLIC HEALTH ACTIVITIES: We may disclose PHI to public health agencies for reasons such as preventing or controlling disease, medical injury, or disability, and/or enable product recalls, repairs or replacements.

Initial: _____

Signature: _____ Date: _____

Print Name: _____

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (part arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each part to the arbitration shall pay such part's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a part for such party's immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** The agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as the date of first medical services _____

Patient or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIALL SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ Date: _____

Physician of Authorized Representative's Signature

_____

Print of stamp Name of Physician, Medical Group, or Association Name

By: _____ Date: _____

Patient or Patient Representative's Signature

_____

Patient Name

_____

(If Representative, Print Name/Relationship to Patient)

A signed copy of this document is to be given to the patient. Original is to be filed in patient's medical records.

HISTORY OF OCCURRENCE

If your accident was a motor vehicle collision, a slip and fall, or other type of injury, please answer all questions that apply to your injury. Please be specific.

Date of accident: _____ Time: _____

Driver of car: _____

Where were you seated? (Please circle): Driver's seat
Front right seat Front middle seat Rear right passenger Rear middle passenger

Rear left passenger

Who owns the car? _____

Year, Make, and model of car: _____

What was the approximate damage done to the car you were in? $ _____

Visibility at the time of accident (Circle): Poor Fair Good

Road conditions at the time of accident (Circle):
Icy Rainy/Wet Clear Dark

Please check all that apply:

☐ My car hit another car

☐ My car was hit on the: ☐ Right ☐ Left ☐ Rear ☐ Front

Type of accident: ☐ Head on collision ☐ Broad-side collision

☐ Rear-end collision ☐ Front impact (rear-ended car in front)

☐ Non-collision (Describe): _____

Description of accident:

_____
_____
_____
_____
_____
_____
_____

PATIENT HEALTH HISTORY

Name: _____ Family Physician: _____

FAMILY HISTORY (CIRCLE ALL THAT APPLY)

Mother: A) Cancer B) Diabetes C) Heart Disease D) High Blood Pressure E) Respiratory Problems D)Kidney E) Stroke F) In good health G) If deceased – age of death _____

Father: A) Cancer B) Diabetes C) Heart Disease D) High Blood Pressure E) Respiratory Problems D)Kidney E) Stroke F) In good health G) If deceased – age of death _____

Siblings: A) Cancer B) Diabetes C) Heart Disease D) High Blood Pressure E) Respiratory Problems D)Kidney E) Stroke F) In good health G) If deceased – age of death _____

SOCIAL HISTORY: (CIRCLE ALL THAT APPLY)

MARITAL STATUS: 1. SINGLE 2. MARRIED 3. DIVORCED 4. WIDOWED
NUMBER OF CHILDREN: (0) (1) (2) (3) (4) (5)
DO YOU: 1. EXERCISE REGULARLY_____ 2. EAT A BALANCED DIET? _____3. OBTAIN SUFFICIENT REST? _____
DO YOU DRINK COFFEE/TEA? HOW MANY CUPS/DAY?: _____
DO YOU SMOKE? HOW MANY PACKS/DAY?: _____
DO YOU DRINK ALCOHOL? HOW MANY DRINKS PER DAY? _____

MEDICAL HISTORY: CIRCLE ALL THAT APPLY

A) CHILDHOOD ILLNESSES: 1) MEASLES 2) MUMPS 3) CHICKENPOX 4) TUBERCULOSIS 5) RHEUMATIC FEVER
7) OTHER: _____

LIST OF ANY BIRTH DEFECTS: _____

HOSPITALIZATIONS & SURGERIES: If you have ever been hospitalized, list reason, and dates.
_____M/D/Y ___/___/___
_____M/D/Y ___/___/___
_____M/D/Y ___/___/___
_____M/D/Y ___/___/___

ADULT/ILLNESSES/INJURIES: 1) DIABETES 2) HEART DISEASE 3) HIGH BLOOD PRESSURE 4) SEIZURES 5) CANCER 6) OTHER
Also list injuries for which you have not been hospitalized; include approximate dates.
_____M/D/Y ___/___/___
_____M/D/Y ___/___/___
_____M/D/Y ___/___/___

MEDICATIONS: LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING OR HAVE TAKEN ON A REGULAR BASIS IN THE LAST SIX MONTHS (INCLUDE HOME REMEDIES)

A)_____ B)_____C)_____
D)_____ E)_____F)_____

PAIN LEVEL WITH MEDICATIONS: _____/10 PAIN LEVEL WITH OUT MEDICATION: _____/10

MEDICATIONS TO WHICH YOU ARE ALLERGIC:

A)_____ B)_____C)_____
D)_____ E)_____F)_____

Name: _____ Date: _____ Date of Injury: _____

Head Trauma Symptoms

Please **circle** all symptoms you currently have **that you did not have** before the accident.

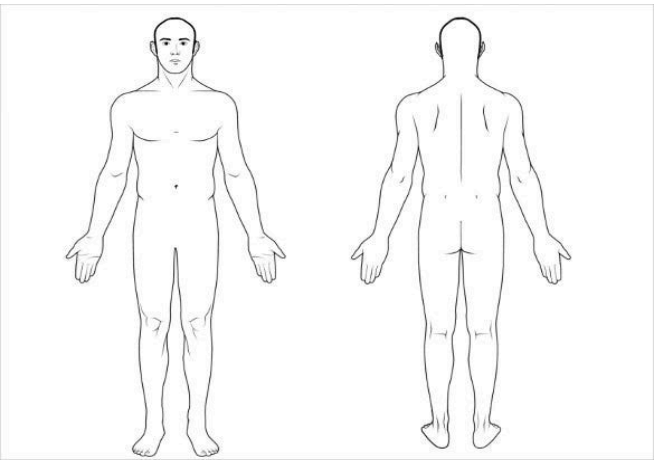
NEUROGICAL SYMPTOMS:

Numbness/Tingling Arm/Hand	Left/Right	Weakness Arm/Hand	Left/Right
Numbness/Tingling Leg/Foot	Left/Right	Weakness Leg/Foot	Left/Right

BRAIN/NEUROPSYCH/MTBI SYMPTOMS:

Range of motion problems
Headaches
Muscle spasms
Dizziness
Visual disturbances
Sleep disruption
Radiating pain
Anxiety
Depression
Wanting to be alone
Sleepiness
Nausea/vomiting
Difficulty concentrating
Day dreaming/Mindless staring
Mood swings
Agitation
Sadness or tearful
Blurry vision
Double vision
Disoriented
Confused
Difficulty speaking
Feeling isolated from others
Attention problems
Appetite changes
Pupils different size
Room spinning/woozy feeling
Balance problems
Difficulty walking
Difficulty focusing/easily distracted
Very tired/dozing during the day
Personality changes
Cannot remember numbers
Reading problems
Writing problems
Difficulty with adding/subtracting
Poor attention
Difficulty learning new things
Re-reading things to understand it
Anger
Difficulty making decisions
Change in sexual function
Reduced confidence
Helplessness
Apathy (don't care)
Irritable
Change in sense of taste or smell
Flashbacks to accident
Impatience
Frustration
Hearing problems
Difficulty planning or organizing
Taking over the counter pain medication

NAME: _____ DATE OF BIRTH: _____ DATE OF SERVICE:_____



PAIN DRAWING INSTRUCTIONS: PLEASE MARK THE AREAS ON YOUR BODY THAT YOU ARE HAVING PAIN.

NO PAIN **WORSE PAIN**

1-2-3-4-5-6-7-8-9-10

BODY PART	WITH MEDICATION	W/O MEDICATION
1.	/10	/10
2.	/10	/10
3.	/10	/10
4.	/10	/10
5.	/10	/10

PLEASE INDICATE AND CIRCLE IF YOU HAVE ANY DIFFICULTY/LIMITATIONS WITH THE FOLLOWING ACTIVITIES OF DAILY LIVING:

CIRCLE ALL THAT APPLY BELOW:	YES, I have difficulty	NO difficulty	Do medications ease this difficulty? YES/NO
BATHING DRESSING EATING			
BRUSHING TEETH COMBING HAIR			
TOILETING (URINATING, DEFECATING)			
WRITING TYPING SEEING RECLINING WALKING			
CLIMBING STAIRS			
HEARING TACTILE FEELING TASTING SMELLING			
GRASPING LIFTING TACTILE DISCRIMINATION			
RIDING DRIVING FLYING			
SEXUAL FUNCTION			
SLEEP RESTFULNESS NOCTURNAL SLEEP PATTERNS			

PLEASE LIST YOUR CURRENT MEDICATIONS: _____

ALLERGIES TO MEDICATIONS: _____

DO YOU EXPERIENCE ANY SIGNIFICANT SIDE EFFECTS WITH ANY PRESCRIBED MEDICATIONS? YES OR NO
IF YES, PLEASE DESCRIBE: _____

DOES ANYTHING ELSE HELP WITH YOU PAIN? (EX: CHIRO, ACUPUNCTURE, PHYSICAL THERAPY)
PLEASE DESCRIBE: _____

SIGNATURE: _____ DATE: _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third part. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information maybe provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information to order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contract you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues are required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extend that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subjected to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment., payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members of friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.